FY 2011

BHO-HCPF Annual Performance Measures Scope Document

Version 4
Created: January 13, 2011
Last updated: October 21, 2011

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(Listed According to BHO Contract)

Introduction

This document includes the details for calculations of the BHO-HCPF Annual Performance Measures for the five Colorado Behavioral Health Organizations (BHOs). Some of these measures are calculated by HCPF using eligibility data and encounter data submitted by the BHOs, other measures are calculated by the BHOs. With the exception of Penetration Rates, all measures are calculated using paid claims/encounters data. Penetration Rates are calculated using paid and denied claims/encounters data.

Performance Measures Indexed by Agency Responsible for Calculation

Calculated by the BHO:

Calculated by HCPF:

Update process:

- Added Appendix A for covered Diagnoses
- Updated with HEDIS 2011 technical specification updates.
- Need to match the names of Performance Measures in contract to scope document when the contract is finalized.
- Add survey for Performance Measure #22, PPD Screening in next year's draft. Survey not done this year.
- HCPF will provide the spreadsheets for Fiscal Year 2010/2011.
- Updated titles of performance measures to match BHO contract.
- Updated original table of contents. Added new index sorted by the agency responsible for calculating the indicator.

Definitions

Members: Individuals eligible for Medicaid assigned to a specific BHO. Membership is calculated by the number of member months during a 12-month period divided by 12, which gives equivalent members or the average health plan enrollment during the 12-month reporting period.

Covered Mental Health Disorder: The BHO Colorado Medicaid Community Mental Health Services Program contract specifies that certain mental health diagnoses are covered. These specific diagnoses can be found below or in the BHO Medicaid BHO contract Exhibit D. Only those services that cover mental health, with the exception of services related to Assessment, Prevention, and Crisis procedure coding as a diagnosis may have yet to be ascribed, will be included in the calculations of performance measures; however, penetration rates will be calculated using both paid and denied claims/encounters, regardless of the mental health diagnoses.

- **295.00-298.99**
- **300.00-301.99**
- **307.00-309.99**
- **311.00-314.99**

Per 1000 members – A measure based on total eligible members per 1000.

Fiscal Year – Based on the State fiscal year July to June

Quarter – Based on fiscal year quarters (Jul-Sep, Oct-Dec, Jan-Mar, Apr-Jun)

Age Category – Based on HEDIS age categories: 0-12 (Child), 13-17 (Adolescent), 18-64 (Adult), and 65+ (Older Adult). Age category determination will be based upon the client's age on the date of service for all performance indicators except for inpatient hospitalization and penetration rates. For inpatient hospitalization, age category determination will be based upon the client's age on the date of discharge. For penetration rates, age category determination will be based upon the age of the client on the last day of the fiscal year.

24 Hour Treatment Facility – A residential facility that has 24-hr professional staffing and a program of treatment services and includes PRTF and TRCCFs. Does not include Nursing Facilities or ACFs (defined as an assisted living residence licensed by the State to provide alternative care services and protective oversight to Medicaid clients).

Hospital Discharge – A discharge from a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis that does not result in a re-hospitalization within 24 hrs (transfer). There can be multiple discharges during the specified fiscal year period. The discharge must result in a paid claim for the hospital episode, except where the discharge is from a State Hospital for ages 21-64. Adult members on the list of discharges from the State hospital who are not eligible at the time of hospital admission should be dropped from the hospital discharge list. Adult members who lose eligibility during the hospital stay may remain on the hospital discharge list.

Hospital Admit – An admission to a hospital (non-residential) for an episode of treatment for a covered mental health diagnosis. There can be multiple admits during the specified fiscal year period. The admission must result in a paid claim for the hospital episode, except where the admission is from a State Hospital for ages 21-64.

HCPF— The Department of Health Care Policy and Financing for the State of Colorado.

HEDIS—Healthcare Effectiveness Data and Information Set

Indicator 1: Hospital readmissions within 7, 30, 90 days post-discharge

Description: Proportion of BHO Member discharges from a hospital episode for treatment of a covered mental health disorder and readmitted for another hospital episode for treatment of a covered mental health diagnosis within 7, 30, 90 days by age group and overall (recidivism rates). Two indicators are provided: 1) **Non-State:** Recidivism rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Recidivism rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at first hospital discharge.

Denominator: Total number of BHO member discharges during the reporting period. The population is based on discharges (e.g., one member can have multiple discharges).

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital during the specified fiscal year
- **All Hospitals:** Total number of Member discharges from all hospitals during the specified fiscal year

Numerator: Number of BHO member discharges with an admission within 7, 30, and 90 days of the discharge, reported cumulatively.

- **Non-State Hospital:** Total number of Member discharges from a non-State hospital, during the specified fiscal year, July 1 through June 30, and then admitted to any hospital (non-state or state) 7, 30, and 90 days after the discharge.
- **All Hospitals:** Total number of Member discharges from all hospitals, during the specified fiscal year, July 1 through June 30, and then admitted to all hospitals 7, 30, and 90 days after the discharge.

Data Source(s): Denominator: Number of Member discharges, from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by HCPF. Numerator: Admissions from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Admissions from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation (6 ratios): Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non state hospital), Numerator (90 days, non state hospital)/Denominator (non state hospital); etc

Benchmark: Overall BHOs.

Indicator 2: Percent of members prescribed redundant or duplicated antipsychotic medication

Description: The proportion of Members, with one or more atypical antipsychotics prescribed, that have, for 120 days or more, two or more different atypical antipsychotic medications prescribed

Denominator: Number of unduplicated members with one or more net value paid pharmacy claims for an atypical antipsychotic medication during the first nine months of the fiscal year studied. The date used to determine whether the claim is within the first nine months is the service date.

Numerator: Number of unduplicated members in the denominator with two concurrent pharmacy claims for an atypical antipsychotic for 120 days or more during the study period. See Table 1 for the list of Typical or Second Generation antipsychotic medications. Refer to **Table 1for Atypical NDC Codes**. The field for determining the prescribed date is the date of the service date. A member is only counted once in the numerator even though they may have more than one 120 day period with two concurrent service dates for an atypical antipsychotic. The study period is the fiscal year.

Use 9 (120 day periods) for the Fiscal Year (see example below).

07/01/09	to	10/31/09
08/01/09	to	11/30/09
09/01/09	to	12/31/09
10/01/09	to	01/31/10
11/01/09	to	02/28/10
12/01/09	to	03/31/10
01/01/10	to	04/30/10
02/01/10	to	05/31/10
03/01/10	to	06/30/10

Break each 120 day period into four 30 day parts (assumption most are for 30 days based on VO analysis 76%). Each member had to have had a fill for 2 different atypical antipsychotics in each 30 day part to be included for the whole period.

TABLE 1
Atypical Antipsychotic
Aripiprazole (Abilify)
Clozapine (Clozaril)
Ziprasidone (Geodon)
Risperidone (Risperdal)
Quetiapine (Seroquel)
Olanzapine (Zyprexa)

Data Source: Pharmacy claims

Calculation of Measure: BHOs. The Department will provide the specified pharmacy claim files to each BHO for calculation

Benchmark: Overall BHO percent

Issues:

1. Assumption that the claims are for a 30 day supply
2. Discuss alignment with new CMS Polytherapy with Oral Antipsychotics measure: more specific methodology (p 36-39) and developed using expert panel
    a. Ages 18+ (p. 1)
    b. Continuously enrolled 1 year (ability to improve outcomes) (p.2)
    c. All oral antipsychotics (excluding clozapine), not just atypicals (p 35)
    d. Excludes clozapine (p. 9, 17)
    e. Uses days supply instead of spans
    f. Denominator (p 3):
        i. "routinely" scheduled: at least 2 "consecutive" dispensings of at least 25 day supply "consecutive" dispensings: days' supply for first dispensing divided by difference in days between first and next dispensing is (MPR) >=.8 (example consecutive: 25/25=1, not consecutive 25/36=.7)
3. Caveat as to completeness of data – Medicare Part B does not share their data; as a result any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

Indicator 3: Percent of members diagnosed with a new episode of major depression, treated with antidepressant medication and maintained on antidepressants for at least 84 days (12 weeks)

Description: Percent of members diagnosed with a new episode of major depression, treated with antidepressant medication, and maintained on antidepressants for at least 84 days (12 weeks). Refer to **Calculation criteria below for complete information on calculating this measure**. **Refer to Table 2 for Antidepressant NDC Codes**.

Denominator: Members ages 18 years and older who were diagnosed with a new episode of major depressive disorder.

Numerator: The number of members in the denominator with an 84 day treatment with antidepressant medication.

Data Source (s): HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: BHOs, Numerator/Denominator

Benchmark: Overall BHOs and HEDIS

Issues:

1. Caveat as to completeness of data – Medicare Part B does not share their data; as a result any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

TABLE 2

Calculation criteria

HEDIS Antidepressant Medication Management (AMM)

For calculating Percent of Members diagnosed with a new episode of major depression, treated and maintained on antidepressants for at least 84 days (12 weeks) performance measure

Summary of Changes to HEDIS 2011

- Deleted UB Revenue code 077x from table AMM-B.
- Deleted ”milnacipran” form the SSNRI antidepressants description from Table AMM-D.

Description

The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

- *Effective Acute Phase Treatment.* The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).

Definitions

Intake Period The 12-month window starting on July 1 and ending on June 30 of the measurement

	year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression (Table AMM-A) that meets the following criteria. • A 120-day Negative Diagnosis History • A 90-day Negative Medication History *For an inpatient (acute or nonacute) claim/encounter*, the IESD is the date of discharge. *For a direct transfer*, the IESD is the discharge date from the facility to which the member was transferred.
Negative Diagnosis History	A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters with any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C). *For an inpatient (acute or nonacute) claim/encounter*, use the date of admission to determine Negative Diagnosis History. *For direct transfers*, use the first admission to determine Negative Diagnosis History.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-D).
Treatment days	The actual number of calendar days covered with prescriptions within the specified 84-day measurement interval.

Eligible Population

Product lines	Medicaid
Ages	18 years and older as of June 30 of the measurement year.
Continuous enrollment	120 days prior to the IESD through 128 days after the IESD.
Allowable gap	To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.
Benefits	Medical, pharmacy (HCPF) and mental health (inpatient and outpatient).
Event/diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for rate.

Step 1 Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311

*****Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying members with major depression.

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 G0409–G0411	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

CPT		POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/encounter for any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C) during the 120 days prior to the IESD.

Table AMM-C: Additional Codes to Identify Depression

Description	ICD-9-CM Diagnosis
Depression	296.26, 296.36, 296.4-296.9, 309.0, 309.28

Step 4 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table AMM-D) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 5 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

***Step* 6** Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IESD to 128 days after the IESD.

• Administrative Specification

Denominator The eligible population.

Numerator

Effective Acute Phase Treatment At least 84 days (12-weeks) of continuous treatment with antidepressant medication (Table AMM-D) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period.

Allowable medication changes or gaps include:

- Washout period gaps to change medication
- Treatment gaps to refill the same medication

Regardless of the number of gaps, there may be no more than 30 gap days. The organization may count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table AMM-D: Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• bupropion		
Monoamine oxidase inhibitors	• isocarboxazid • phenelzine	• selegiline • tranylcypromine	
Phenylpiperazine antidepressants	• nefazodone	• trazodone	
Psychotherapeutic combinations	• amitriptyline-chlordiazepoxide • amitriptyline-perphenazine		• fluoxetine-olanzapine
SSNRI antidepressants	• desvenlafaxine • duloxetine	• venlafaxine	
SSRI antidepressants	• citalopram • escitalopram	• fluoxetine • fluvoxamine	• paroxetine • sertraline
Tetracyclic antidepressants	• maprotiline	• mirtazapine	
Tricyclic antidepressants	• amitriptyline • amoxapine • clomipramine	• desipramine • doxepin • imipramine	• nortriptyline • protriptyline • trimipramine

Note: *NCQA posted a comprehensive list of medications and NDC codes to www.ncqa.org on December 7, 2010. NDC codes are in excel Attachment 2.*

. Note

Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others

may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).

Indicator 4: Improvement in symptom severity: Child

Detailed description for this indicator: Change in symptom severity for youth, age 6 through 17 years, including mental functioning, sociability, depression/suicidality or mood disturbance and family, and substance abuse/legal.

Description: The mean change in symptom severity for each of the four CCAR symptom outcome subscales for adolescents, age 12-17 years and three subscales for children, age 6-11, within an episode of care ending with the client discharge. There is one episode of care per client. The episode of care begins with the admit CCAR or the first update CCAR after 7/1/07.

See Table 3 for the calculation criteria for CCAR outcome items by the symptom subscales for adolescents and children. There are four indicators for improvement in symptom severity for adolescents and three for children.

Denominator: Total number of unduplicated members, age 6-17 years, with a discharge CCAR in the study period and a previous admit. CCAR or first update CCAR beginning with July, 2007. The discharge CCAR must be either a type 1, 2, 3, or 7 and, if the discharge CCAR is 1 or 7 the client length of stay, from admit, must be greater than 180 days. If there are two discharge CCARs in the study period the most recent discharge CCAR will define the episode of care. The admit or update CCAR, for the subscale measured must have a mean score ≥ 2. The client must be a member of the same BHO on the date of both CCARs. Two denominators are calculated, one for children age 6-11 and the other for adolescents, age 12-17. Age is calculated by the age at the last CCAR.

Numerator: Total change score for all unduplicated clients within the denominator, from either admit or update and discharge. The numerator is calculated for each the three subscales for each client in the denominator.

Data Source(s): CCARs beginning with 7/1/07

Calculation of Measure: HCPF.

Benchmark:

Issues: Need to coordinate with DBH regarding the factor changes and criteria for calculating this indicator.

TABLE 3

Calculation criteria

Colorado Client Assessment Record Subscale Items for Change in Symptom for Adolescent and Youth Severity Tables

CCAR Subscale for Adolescents (12-17)	CCAR Items in Subscale
Mental Functioning	Cognition
	Attention
	Self-care/Basic Needs
	Manic Issues
	Psychosis
Sociability	Security/Supervision
	Socialization
	Aggression/Danger to Others
Depression/Suicidality	Depressive Issues
	Suicide/Danger to Self

CCAR Subscale for Children (age 6-11)	CCAR Items in Subscale
Mental Functioning & Physical Health	Cognition
	Physical Health
	Self-care/Basic Needs
	Attention
Sociability	Aggression/Danger to Others
	Socialization
	Security/Supervision
	Interpersonal
Mood Disturbance and Family	Depressive Issues
	Anxiety Issues

Indicator 5: Improvement in symptom severity: Adult

Detailed description for this indicator: Change in symptom severity for adults, including mental functioning, sociability/substance use, and mood disturbance.

Description: The mean change in symptom severity for each of the three CCAR symptom outcome subscales for adults, age 18 years or older, within an episode of care, ending with the client discharge. There is one episode of care per client. The episode of care begins with the admit CCAR or the first update CCAR after 7/1/07.

See Table 4 for the calculation criteria below for Adults for CCAR outcome items by the three symptom subscales. There will be three indicators for Improvement in symptom severity: improvement in mental functioning, improvement in sociability/substance use, and improvement in mood disturbance.

Denominator: Total number of unduplicated members, age 18 years and older, with a discharge CCARs in study period and a previous admit CCAR or first update CCAR beginning with July 1, 2007 for each episode of care. The discharge CCAR must be either a type 1, 2, 3, or 7 and, if the discharge CCAR is 1 or 7 the client length of stay, from admit, must be greater than 180 days. If there are two discharge CCARs in the study period the most recent discharge CCAR will define the episode of care. The admit or update CCAR, for the subscale measured must have a mean score of $\geq$ 2. The client must be a member in the same BHO on the date of both CCARs).

Numerator: Total change score for all clients within the denominator, from either admit or update to discharge. The numerator is calculated for each of the three subscales for each client in the denominator.

Data Source (s): CCARS beginning with 7/1/07.

Calculation of Measure: HCPF

Benchmark:

Issues:

Need to coordinate with DBH regarding the factor changes and criteria for calculating this indicator

TABLE 4

Calculation criteria

Colorado Client Assessment Record Subscale Items for Change in Symptoms Severity for Adults

CCAR Symptom Subscale for Adults	CCAR Items in Subscale
Mental Functioning	Cognition
	Self-Care/Basic Needs
	Security/Supervision
	Psychosis
	Attention
Sociability/Substance Use	Legal
	Socialization
	Drug Use
	Alcohol Use
	Aggression/Danger to Others
Mood Disturbance	Depressive Issues
	Anxiety Issues
	Suicide/Danger to Self

Indicator 6: Maintaining independent living status for members with severe mental illness (SMI)

Description: The percent of clients, age 18 years and older, living independently, that maintain this status during the measurement period.

Denominator: Total number of unduplicated clients with a SMI **(see Table 5 for how to determine with SMI status for adults)** with an update or discharge CCAR in the study period and a previous CCAR (admit or update) completed no later than within the previous fiscal year, where the Place of Residence is rated as 15 (independent living). The client must be a member of the same BHO on both CCARs.

Numerator: Total number of clients in the denominator whose place of residence is 15 (independent living) on the most recent CCAR

Data Source(s): The most recent CCAR for the fiscal year and the previous CCAR.

Calculation of Measure: HCPF

Benchmark: Overall BHOs

Issues: None

TABLE 5

Severe Mental Illness Definition for all Adults

Severe Mental Illness includes Adults with SPMI and SMI; all steps 1-3 must be completed in order to calculate the full list of Adults with SMI.

Step 1. Diagnosis

Exclusions -Adults and Older Adults with the following **AXIS I Primary Diagnoses** on the CCAR form automatically **DO NOT MEET ANY OF THE SEVERITY LEVEL CATEGORIES.**

Description	Primary Diagnosis Code (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementias & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X
Other	799.9, V71.09

Step 2. SPMI – Serious and Persistent Mental Illness

For an Adult or Older Adult to meet the criteria for SPMI, s/he must first pass the Exclusion criteria in Step 1 and then meet the criteria in the History and/or Self Care categories below: Any THREE of the following History items on the CCAR form must be met:

History Criteria	Value
SSI (265)	"1"
SSDI (266)	"1"
Presenting Problem has Existed (283)	"1"
Inpatient Care (360)	"1"
Other 24-Hour Care (361)	"1"
Partial Care (362)	"1"

Or any four of the following Self Care Items must be met:

Self Care Criteria	Value
Place of Residence (270)	All codes except "12" and "15"
Self Care Problems (294)	"1"
Food Attainment (295)	"1"
Housing Access (296)	"1"
Self-Care/Basic Needs (384)	"7-9"

Step 3. SMI not SPMI

For those cases remaining (not excluded by diagnosis and not SPMI): Severity level is determined by the presence of a **Serious Mental Illness** as defined by these diagnosis codes:

Description	Primary Diagnosis Code (217)
Schizophrenia & other Psychosis	295.1X, .2X, .3X, .6X, .9X
Paranoid	297.1, 297.3
Other Psychosis	295.4X, .7X, 298.8, .9
Major Affective	296.X, 296.XX, 300.4, 311
Personality Disorder	301.0, .20, .22
Dissociative Identify Disorder	300.14
Post-Traumatic Stress	309.81 plus the score for the Overall Symptom Severity must be a 4 or higher.

Any adult not meeting the SPMI or SMI not SPMI criteria is not SMI.

NOTE: A client meeting both SPMI and SMI not SPMI is recorded in the Management Information System as SPMI.

Serious Mental Illness (SMI) – The national definition for SMI is much broader than the one used in Colorado. To update the Colorado severity level categories, the Division of Mental Health will combine SPMI and SMI not SPMI into a single SMI category.

Indicator 7: Progress toward independent living for members with severe mental illness (SMI)

Description: The percent of clients, age 18 years and older, who move to a less restricted place of residence, including independent living, during the measurement period.

Denominator: Total number of unduplicated clients with a severe mental illness (SMI) **(see Table 6 to determine SMI status for adults)** with an update or discharge CCAR in the study period with a previous CCAR (admit or update) completed no later than within the previous fiscal year, where the Place of Residence is not rated as 15 (independent living) on the previous CCAR. The client must be a member of the same BHO on both CCARs.

Numerator: Total number of clients in the denominator with a gain in a place of residence that is less restrictive.
Criteria for gain: Movement from a lower numbered category to a higher numbered category (**see Table 6 for categories and numbers**)

Data Source(s): The last CCAR for the study period and the previous CCAR

Calculation of Measure: HCPF

Benchmark: Overall BHOs

Issues: Need to be sure categories are organized accurately re: restriction in living arrangement.

TABLE 6

Severe Mental Illness Definition for all Adults

Severe Mental Illness includes Adults with SPMI and SMI; all steps 1-3 must be completed in order to calculate the full list of Adults with SMI.

Step 1. Diagnosis

Exclusions -Adults and Older Adults with the following **AXIS I Primary Diagnoses** on the CCAR form automatically **DO NOT MEET ANY OF THE SEVERITY LEVEL CATEGORIES.**

Description	Primary Diagnosis Code (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementias & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X
Other	799.9, V71.09

Step 2. SPMI – Serious and Persistent Mental Illness

For an Adult or Older Adult to meet the criteria for SPMI, s/he must first pass the Exclusion criteria in Step 1 and then meet the criteria in the History and/or Self Care categories below: Any THREE of the following History items on the CCAR form must be met:

History Criteria	Value
SSI (265)	"1"
SSDI (266)	"1"
Presenting Problem has Existed (283)	"1"
Inpatient Care (360)	"1"
Other 24-Hour Care (361)	"1"
Partial Care (362)	"1"

Or any four of the following Self Care Items must be met:

Self Care Criteria	Value
Place of Residence (270)	All codes except "12" and "15"
Self Care Problems (294)	"1"
Food Attainment (295)	"1"
Housing Access (296)	"1"
Self-Care/Basic Needs (384)	"7-9"

Step 3. SMI not SPMI

For those cases remaining (not excluded by diagnosis and not SPMI): Severity level is determined by the presence of a **Serious Mental Illness** as defined by these diagnosis codes:

Description	Primary Diagnosis Code (217)
Schizophrenia & other Psychosis	295.1X, .2X, .3X, .6X, .9X
Paranoid	297.1, 297.3
Other Psychosis	295.4X, .7X, 298.8, .9
Major Affective	296.X, 296.XX, 300.4, 311
Personality Disorder	301.0, .20, .22
Dissociative Identify Disorder	300.14
Post-Traumatic Stress	309.81 plus the score for the Overall Symptom Severity must be a 4 or higher.

Any adult not meeting the SPMI or SMI not SPMI criteria is not SMI.

NOTE: A client meeting both SPMI and SMI not SPMI is recorded in the Management Information System as SPMI.

Serious Mental Illness (SMI) – The national definition for SMI is much broader than the one used in Colorado. To update the Colorado severity level categories, the Division of Mental Health will combine SPMI and SMI not SPMI into a single SMI category.

Categories of CCAR Place of Residence with increasing restrictive living with lower number assigned to category:

7 = independent Living (rating of "15" on CCAR)
6 = supported housing (13)
5 = boarding home (6) & group home (7), assisted living (14)
4 = residential (9,10)
3 = nursing home (8)
2 = ATU
1 = inpatient (2), correctional facility (01)
0 = homeless

Indicators 8-11: Penetration rates (including breakouts by HEDIS age groups, Medicaid eligibility category, race, and service category)

Description: Percent BHO Members with one contact (paid or denied) in a specified fiscal year (12-month period) by HEDIS age group, Medicaid eligibility category **(refer to Table 7 for eligibility categories)**, race **(refer to Table 7 for race/ethnicity categories)**, and service category **(refer to Table 8 for HEDIS specs and additional place of service (POS) and service codes.)**

- HEDIS age group is determined by the member's age on the last day of the fiscal year**.**
- Medicaid eligibility category is the eligibility category on the member's most recent Medicaid eligibility span during the fiscal year.
- Race/ethnic group is the race category on the member's most recent Medicaid eligibility span during the fiscal year.
- Service category is defined any paid or denied MH service grouped as inpatient, intensive outpatient/partial hospital, and ambulatory care in a specified fiscal year 12-month period. POS category 53 will be excluded for the intensive outpatient and partial hospitalization service category.
- Mental health managed care enrollment spans with at least one day of enrollment during the fiscal year are analyzed.
- All enrollment spans identified as: enrollment begin date <= the last date of the fiscal year (6/30) AND enrollment end date >= the first date of the fiscal year (7/1).
- Member months are determined by counting number of clients with an enrollment span covering at least one day in the month, i.e., total member months per month as: enrollment begin date <= last day of the month AND enrollment end date >= first day of the month. Thus, if the client is enrolled for the full month the member month is equal to one and if enrolled for less than the full month the member month is a fraction between 0 and 1.
- BHO - Behavioral Health Organization
- FY - fiscal year
- FTE - full time equivalent
- MM - member months
- NOTE: The Data Analysis Section tailors data to specific internal and external customer needs that are not met through existing reporting. Thus, calculations may differ from existing published figures due to several factors that may include, but are not limited to: the specificity of the request, retroactivity in eligibility determination, claims processing and dollar allocation differences between MMIS and COFRS.

Denominator: Total BHO membership for the specified fiscal year (12-month period)

Numerator: Members with any MH service in the specified fiscal year (12-month period) in each age group, Medicaid eligibility category, race/ethnic group, and by service category grouped as inpatient, intensive outpatient/partial hospitalization, and ambulatory care.

Data Source(s): BHO claims/encounter file (both paid and denied claims/encounters will be used).

Calculation of Measure: HCPF (by Overall, HEDIS age, eligibility category, cultural/ethnic [% total missing])

Benchmark: Overall BHO

TABLE 7

Medicaid Eligibility and Race/Ethnicity Categories

Medicaid Eligibility Categories:

Eligibility Type Code	Description
001	OAP-A
002	OAP-B-SSI
003	AND/AB-SSI
004	AFDC/CWP Adults
005	AFDC/CWP CHILDREN
006	FOSTER CARE
007	BC WOMEN
008	BC CHILDREN
020	BCCP-WOMEN BREAST&CERVICAL CAN

Medicaid Race Categories:

Race Code	Description
1	SPANISH AMERICAN
2	OTHER – WHITE
3	BLACK
4	AMERICAN INDIAN
5	ORIENTAL
6	OTHER
7	UNKNOWN
8	NATV HAWAIIAN OTH PACIFIC ISL

TABLE 8

Penetration Rates by Service Category

For calculating the penetration rates by service category performance measure

Description

The number and percentage of members receiving the following mental health services during July 1 and June 30 of the fiscal year.

- Any services
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Calculations

Count members who received inpatient, intensive outpatient, partial hospitalization, and outpatient and ED mental health services in each column. Count members only once in each column, regardless of number of visits. Count members in the *Any Services* column for any service during the measurement year.

For members who have had more than one encounter, count in each column only once and report the member in the respective age category as of the last date of the fiscal year (6/30).

Member months Report all member months during the measurement year for members with the benefit. Refer to *Specific Instructions for Use of Services Tables.* Because some organizations may offer different benefits for inpatient and outpatient mental health services, denominators in the columns of the member months table may vary. The denominator in the *Any* column should include all members with any mental health benefit.

Inpatient Include inpatient care at either a hospital or treatment facility with a covered mental health disorder as the principal diagnosis: 290.xx, 293-302.xx, 306-316.xx.

Use one of the following criteria to identify inpatient services.

An Inpatient Facility code in conjunction with a covered mental health diagnosis. Include discharges associated with residential care and rehabilitation.

Codes to Identify Inpatient Service

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919
ATU codes : 190, H2013, H0018AT
RTC codes : H2013, 0191, 0192, 0193, H0018, H0019, S5135

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Codes to Identify Intensive Outpatient and Partial Hospitalization Services:

HCPCS	UB Revenue	
Visits identified by the following HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,	
CPT		**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52

Codes to Identify Outpatient and ED Services: Additional BHO codes & POS

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90804-90815, 96101-3, 96105, 96110, 96111, 96116, 96118-20, 96125	G0155, G0176, G0177, G0409, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769, 045x

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	05, 07, 11, 12, 15, 20, 22, 23, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99

CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.	
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537	045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

* POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2011 specifications.

Indicator 12: Utilization rates by inpatient, intensive outpatient or partial hospitalization, and ED

12a. Utilization rate by Inpatient

Description: The percent of BHO consumers with at least one discharge from a hospital episode for treatment of a covered mental health disorder, by age group (refer to **Table 9**). The discharge must occur in the period of measurement. Age for this indicator is determined at beginning of first hospital discharge.

Denominator: Total number of BHO consumers with at least one contact (paid) during the specified fiscal year (12-month period).

Numerator: Number of BHO consumers with at least one discharge from a hospital episode for treatment of a covered mental health disorder.

Data Source(s): Denominator: Count of consumers who received at least one service during the measurement period, provided by each BHO based on paid claims in the BHO transaction system. Numerator: Count of consumers with at least one discharge from a hospital episode for treatment of a covered mental health disorder provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator/DenominatorX100

Benchmark: None, not able to compare between BHOs

Problems/Issues/Questions:
Count the consumer only once even if they had several hospitalizations

12b. Utilization rate by Intensive Outpatient or Partial Hospitalization

Description: The percent of BHO consumers with at least one Intensive Outpatient or Partial Hospitalization service (refer to **Table 9 for Intensive Outpatient or Partial Hospitalization codes**).

Denominator: Total number of BHO consumers with at least one contact (paid) during the specified fiscal year (12-month period).

Numerator: Number of BHO consumers with at least one Intensive Outpatient or Partial Hospitalization during the measurement period.

Data Source(s): Denominator: Count of consumers who received at least one service during the measurement period, provided by each BHO based on paid claims in the BHO transaction system. Numerator: Count of consumers with at least one Intensive Outpatient or Partial Hospitalization claim during the measurement period provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Numerator /DenominatorX100

Benchmark: None, not able to compare between BHOs

Problems/Issues/Questions: None

12c. Utilization rate by Outpatient

Description: The percent of BHO consumers with at least one Outpatient service (refer to **Table 9 for Outpatient Codes**).

Denominator: Total number of BHO consumers with at least one contact (paid) during the specified fiscal year (12-month period).

Numerator: Number of BHO consumers with at least one Outpatient claim during the measurement period.

Data Source(s): Denominator: Count of consumers who received at least one service during the measurement period, provided by each BHO based on paid claims in the BHO transaction system. Numerator: Count of consumers with at least one Outpatient claim during the measurement period provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Numerator /DenominatorX100

Benchmark: None, not able to compare between BHOs

Problems/Issues/Questions:

1. Identify this list and then remove consumers that were included in other measures so there's no duplication of some codes.
2. **Item will NOT be calculated for the December 1, 2011 deadline but will possibly be revisited in FY12.**

12d. Utilization rate by ED

Description: The percent of BHO consumers with at least one ED service (refer to **Table 9 for ED Codes**).

Denominator: Total number of BHO consumers with at least one contact (paid) during the specified fiscal year (12-month period).

Numerator: Number of BHO consumers with at least one ED claim for treatment of a covered mental health disorder during the measurement period. ED visits that don't result in an inpatient admission within 24 hrs of the day of the ED visit. ED visit codes include: CPT 99281-99285 and 99291-99292; and revenue code 45x.

Data Source(s): Denominator: Count of consumers who received at least one service during the measurement period, provided by each BHO based on paid claims in the BHO transaction system Numerator: Count of consumers with at least one ED claim during the measurement period provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 100

Benchmark: None, not able to compare between BHOs

Problems/Issues/Questions:
Count services provided by physicians and non-physician practitioners. Only include ED visits that do not result in an inpatient stay.

TABLE 9

Codes to Identify Inpatient, Intensive Outpatient, Partial Inpatient, and Outpatient Services

Codes to Identify Inpatient Services

Inpatient Facility codes : 100, 101, 110, 114, 124, 134, 144, 154, 204
Sub-acute codes : 0919

Codes to Identify Intensive Outpatient and Partial Hospitalization Services

HCPCS	UB Revenue	
Visits identified by the following HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
G0410, G0411, H0035, H2001, H2012, S0201, S9480	0905, 0907, 0912, 0913,	
CPT		**POS**
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	52
Visits identified by the following CPT/POS codes must be with a mental health practitioner.		
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52

Codes to Identify Outpatient Services

CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS, UB Revenue and CPT/POS codes may be with a mental health or non-mental health practitioner (the organization does not need to determine practitioner type).		
90804-90815, 96101-3, 96105, 96110, 96111, 96116, 96118-20, 96125	G0155, G0176, G0177, G0409, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013-H2020, M0064, S9484, S9485, T1005, T1016, T1017, H0033, H0038, H0043, H0046, H2012, H2021, H2022, H2023, H2024, H2025, H2026, H2030, H2031, H2032, S0220, S0221, S9449, S9451, S9452, S9453, S9454, S9470	0513, 0900-0904, 0911, 0914-0919, 0762, 0769
CPT		**POS**
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	05, 07, 11, 12, 15, 20, 22, 23, 49, 50, 53*, 71, 72, 19, 26, 32, 34, 41, 99
CPT		**UB Revenue**
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner.		
98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99281-99285, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99510, 90772, 97535, 97537		045x, 0510, 0515-0517, 0519,-0523, 0526-0529, 0762, 0981-0983

***POS 53 identifies visits that occur in an outpatient, intensive outpatient or partial hospitalization setting. If the organization elects to use POS 53 for reporting, it must have a system to confirm the visit was in an outpatient setting.

- Note: The specifications presented here for the Penetration Rates by Service Category performance indicator are closely based upon HEDIS 2011 specifications.

Indicator 13: Follow-up appointments within seven (7) and thirty (30) days after hospital discharge

Description: The percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health disorder to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider by age group and overall within 7 or 30 days (follow-up rates). Two indicators are provided: 1) **Non-State:** Follow-up rates for member discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) **All hospital:** Follow-up rates for member discharges from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age group is defined as 6 years and older as of the date of discharge.

Numerators: Total number of discharges with an outpatient service (**see Table 10)** within 7 and 30 days (the 30 days includes the 7 day number also). For each denominator event (discharge), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure. See CPT, UB-92, HCPCS codes in **Table 10 for follow-up visit codes allowed**.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year with an outpatient service within 7 and 30 days.
All Hospitals: All discharges from any inpatient facility for a specified fiscal year with an outpatient service within 7 and 30 days.

Denominators: The population based on discharges during the specified fiscal year July 1 through June 30 (can have multiple discharges for the same individual). Discharges for the whole fiscal year are calculated because the use of 90 day run out data provides the time to collect 30 day follow-up information.
Non-state Hospital: All discharges from a non-state hospital during the specified fiscal year.
All Hospitals: All discharges from any inpatient facility for the specified fiscal year.

Exclusions:

- Exclude those individuals who were readmitted within 30 days to an inpatient setting for all calculations
- Exclude discharges followed by admission to any non-acute treatment facility within 30 days of hospital discharge for any mental health disorder. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.
- Refer to HEDIS codes in **Table 10** to identify nonacute care. For residential treatment, compare using residential treatment per diem code. Due to the fact that residential treatment for Foster Care members is paid under fee-for-service, the BHOs cannot easily determine if a Foster Care member was discharged to residential treatment. Therefore, prior to official rate reporting, the HCPF Business Analysis Section will forward each BHO a list of foster care members who were discharged from an inpatient setting to a residential treatment facility, in order to assist the BHOs in removing these members from this measure.

Data Source(s): Denominator: Number of Member discharges, from non-State hospitals, ages 6+, and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the State. Numerator: An outpatient visit, intensive outpatient encounter or partial hospitalization provided by each BHO based on paid claims in the BHO transaction system.

Calculation of Measure: BHO; Calculation: Includes 4 ratios: Numerator (7 days, non-state hospital)/Denominator (non-State hospital); Numerator (30 days, non-state hospital)/Denominator (non

state hospital), Numerator (7 days, all hospital)/Denominator (all hospital), Numerator (30 days, all hospital)/Denominator (all hospital)

Benchmark: HEDIS and all BHOS

TABLE 10

HEDIS Follow-Up After Hospitalization for Mental Illness (FUH)

For calculating Follow-up after hospitalization for mental illness performance measure

Description

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of a covered mental health disorder and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

1. The percentage of members who received follow-up within 30 days of discharge
2. The percentage of members who received follow-up within 7 days of discharge

Eligible Population

Ages	6 years and older as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a covered mental health diagnosis during July1 and June 30 of the fiscal year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge during July1 and June 30 of the fiscal year.
Mental health readmission or direct transfer	If the discharge is followed by readmission or direct transfer to an *acute facility* for any covered mental health disorder within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after June 30 of the fiscal year. Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for any covered mental health disorder within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the following table for codes to identify nonacute care.

Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other nonacute care facilities that do not use the UB Revenue or Type of Bill codes for billing (e.g., ICF, SNF)				

Administrative Specification	
Denominator	The eligible population.
Numerators	
30-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.
7-day follow-up	An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge. Refer to the following table for appropriate codes.

Codes to Identify Visits

CPT	HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409, G0410, G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT	**POS**
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.	

90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	***WITH***	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255,	***WITH***	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB Revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following Revenue codes must be with a mental health practitioner or in conjunction with any diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

- Note: The specification presented here for the Follow up Post Discharge performance indicator are closely based upon HEDIS 2011 specifications.

Indicator 14: Percent of members with SMI with a focal point of behavioral health care

Description: The percent of members with SMI who have a focal point of care identified and established.

Denominator: Total number of unduplicated members meeting the following criteria:

- 21 years of age or older on first day of the measurement period (SFY)
- Continuously enrolled 12 out of 12 months in the same BHO during the measurement period (SFY)
- Identifying outpatient service with an SMI diagnosis- at least one paid BHO outpatient service (refer to **Table 11**) in the first 9 months of the measurement period (SFY) for diagnoses in any position (refer to **Table 11 for SMI diagnoses**). This identifies clients that are on either a Treatment or Med Management Track.

Numerator: Total number of members in the denominator that meet at least one of the following track criteria (using **Table 11**) with the same billing provider during the measurement period (SFY).

- Treatment/Recovery Track- At least 3 Treatment/Recovery or Case Management or Med Management visits
- Med Management Track- At least 2 Med Management visits

Data Source(s): BHO transaction system.

Calculation of Measure: BHO, Numerator/Denominator

TABLE 11

Codes to Identify BHO Outpatient Services

Service Domain and/or Category	CPT/HCPCS Procedure Code		POS
Assessment	90801-2, H0031		11, 50, 53, 71, 72
Treatment/Recovery (Psychotherapy, Svc planning, Vocational, Peer support)	90804-19, 90821-9, 90846-7, 90849, 90853, 90857, H0032 H0004, H0036-40, H2014-8, H2023–7, H2030-2	**WITH**	
Case Management	T1016-7		
Med Management	90862, 96372, 99441-3, H0033-4		

SPMI Diagnosis Codes

Diagnosis	ICD-9-CM
Schizophrenia	295.10, 295.1, 295.20, 295.2, 295.30, 295.3, 295.60, 295.6, 295.90, 295.9
Schizoaffective disorder	295.70, 295.7
Bipolar disorder	296.0x, 296.40, 296.4, 296.4x, 296.5x, 296.6x, 296.70, 296.7

Indicator 15: Improving physical healthcare access

Description: The total number of Members who received outpatient mental health treatment during the measurement period and also had a qualifying physical healthcare visit during the measurement period

Denominator: Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least ten months with the same BHO during the 12-month measurement period.

Numerator: Total number of members in the denominator with at least one preventive or ambulatory medical visit as defined using the service codes in **Table 12** during the measurement period, excluding those services provided by rendering provider type codes identified in **Table 12**.

Data Source(s): The encounter/claims files (BHO, MCO, Fee for Service) for the fiscal year, including paid claims, provided by HCPF

Calculation of Measure: HCPF

Benchmark: Overall BHO

TABLE 12

Preventive or Ambulatory Medical Visits Table AAP-A: Codes to Identify Preventive/Ambulatory Health Services (HEDIS 2011)

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Rendering Provider Type Code Exclusions

Rendering Provider Type Code	Rendering Provider Type Description
06	Podiatrist
11	Case Manager
07	Optometrist
27	Speech Therapist
12	Independent Laboratory

Indicator 16: Inpatient utilization (per 1000 members)

Description: The total number of BHO member discharges from a hospital episode for treatment of a covered mental health disorder per 1000 members, by age group (see above for age categories) and total population. The discharge must occur in the period of measurement. Two indicators are provided: 1) Number of member discharges from a non-State hospital and 2) Number of member discharges from all hospitals (non-State and State hospitals). Age for this indicator is determined at hospital discharge. Please note: For members transferred from one hospital to another within 24 hours, only one discharge should be counted and it should be attributed to the hospital with the final discharge.

Denominator: Total number of members during the specified fiscal year (12-month period).

Numerator: All discharges from a hospital episode for treatment of a covered mental health disorder
Non-State Hospitals: All discharges from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.
All Hospitals: All discharges from a hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30.

Data Source(s): Denominator: Members by BHO provided by HCPF. Numerator: Discharge dates from non-State hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Discharge dates from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-state hospital)/Denominator x 1000; Numerator (all hospital)/Denominator x 1000

Benchmark: HEDIS for all hospital and Overall BHOs for all hospital and non-State hospital

Indicator 17: Hospital length of stay (LOS)

Description: The average length of stay (in days) for BHO members discharged from a hospital episode for treatment of a covered mental health disorder, by age group and total population. Two indicators are provided: 1) Average length of stay for members discharged from a non-State hospital episode for treatment of a covered mental health disorder during the specific fiscal year, July 1 through June 30 and 2) Average length of stay for members discharged from all hospital episodes for a covered mental health disorder during the specific fiscal year, July 1 through June 30. Age for this indicator is determined at hospital discharge.
Please note: For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals should be attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission.

Denominators: Number of Members discharged from a hospital episode. The discharge day must occur within the specified fiscal year, July 1 through June 30.

Non-State Hospital: Total number of Members discharged from a non-State hospital during the specified fiscal year
All Hospitals: Total number of Members discharged from all hospitals during the specified fiscal year.

Numerators: Total days for all hospital episodes resulting in a discharge. Discharge day is not counted. The discharge day must occur within the specified fiscal year, July 1 through June 30. If the admit date and the discharge date are the same then the number of days for the episode is one.
Non-State Hospitals: Total days= Discharge date from the non-State hospital-Admit date
All Hospitals: Total days=Discharge date from all hospitals-Admit date

Data Source(s): Denominator: Number of Members discharged, from non-State hospitals and State hospitals, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Number of discharges from the State hospital system, ages 21 through 64 years, will be provided by the state hospital data file. Numerator: Hospital days (discharge date – admit date) from private hospitals and State hospital, for ages through 20 years and 65+, provided by each BHO based on paid claims in the BHO transaction system. Hospital days (discharge date – admit date) from the State hospital system, ages 21 through 64 years, will be provided by the State.

Calculation of Measure: BHO; Calculation: Numerator (non-State hospital)/Denominator (non-State hospital); Numerator (all hospital)/Denominator (all hospital)

Benchmark: BHO for all hospital and non-State hospital

Indicator 18: Emergency department utilization (per 1000 members)

Description: Number of BHO Member emergency room visits for a covered mental health disorder per 1,000 Members by age group and overall for the specified fiscal year 12-month period. For this measure include only paid encounters. Age for this indicator is determined on date of service.

Denominator: Total number of Members during the specified fiscal year (12-month period).

Numerator: ED visits that don't result in an inpatient admission within 24 hrs of the day of the ED visit. ED visit codes include: CPT 99281-99285 and 99291-99292; and revenue code 45x.

Data Source(s): Denominator: HCPF; Numerator: BHO encounter claim file.

Calculation of Measure: BHO; Calculation: Numerator/Denominator x 1,000

Benchmark: Overall BHO

Indicator 19: MHSIP & YSS-F Satisfaction Surveys

Description: The Colorado Division of Behavioral Health conducts annual adult and youth surveys to assess satisfaction with mental health services at each of the Colorado community mental health centers. Refer to the current state fiscal year MHSIP and YSS-F technical reports for complete methodology. This report can be found on the State of Colorado Division of Behavioral Health website.

Denominator: Number of MHSIP (adults) or YSSF (youth) surveys complete for each individual community mental health center, aggregated by BHO.

Numerator: The number in the denominator who indicate they are satisfied with the MHSIP (adults) or YSS-F (youth) domains.

Data Source (s): DBH data

Calculation of Measure: HCPF for the BHOs

Benchmark: Overall BHOs

Indicator 20: Antidepressant medication management-optimal practitioner contacts

Description: Percent of members diagnosed with a new episode of major depression, treated with antidepressant medication, and who had at least 3 follow up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks). Refer to **Table 13 for specific criteria on calculating this measure**.

Denominator: Members ages 18 years and older who were diagnosed with a new episode of major depressive disorder and treated with antidepressant medication.

Numerator: The number of members in the denominator who had at least 3 follow-up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks)

Data Source (s): HCPF quarterly pharmacy file; BHO encounter data

Calculation of Measure: BHOs
Benchmark: Overall BHOs

TABLE 13

Antidepressant Medication Management (AMM)-Optimal Practitioner Contacts

Description

The percentage of members 18 years of age and older as of June 30 of the measurement year who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who had at least three follow-up contacts with a practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase. At least one of the three follow-up contacts must be with a prescribing practitioner.

Definitions

Intake Period	The 12-month window starting on July 1 and ending on June 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression (Table AMM-A) that meets the following criteria. • A 120-day Negative Diagnosis History • A 90-day Negative Medication History *For an inpatient (acute or nonacute) claim/encounter*, the IESD is the date of discharge. *For a direct transfer*, the IESD is the discharge date from the facility to which the member was transferred.
Negative Diagnosis History	A period of 120 days (4 months) prior to the IESD, during which time the member had no claims/encounters with any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C). *For an inpatient (acute or nonacute) claim/encounter,* use the date of admission to determine Negative Diagnosis History. *For direct transfers,* use the first admission to determine Negative Diagnosis History.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD, during which time the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication (Table AMM-D).
Treatment days	The actual number of calendar days covered with prescriptions within the specified 84-day measurement interval.

Eligible Population

Product lines	Medicaid
Ages	18 years and older as of June 30 of the measurement year.
Continuous enrollment	120 days prior to the IESD through 128 days after the IESD.
Allowable gap	To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IESD.
Benefits	Medical, pharmacy (HCPF) and mental health (inpatient and outpatient).
Event/diagnosis	The organization should follow the steps below to identify the eligible population, which should be used for rate.

Step 1 Identify all members who met at least one of the following criteria during the Intake Period.

- At least one principal diagnosis of major depression (Table AMM-A) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B), ***or***
- At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table AMM-B) on different dates of service with any diagnosis of major depression (Table AMM-A), ***or***
- At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table AMM-A)

Table AMM-A: Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311

*****Brief depressive reaction (309.0) is not used for diagnosis, since it includes grief reaction (believed to be the most common use of that code). Additionally, other possible codes that could indicate a depression diagnosis (296.4–296.9, 309.0, 309.28) are not included in this list because these codes are less specific in identifying members with major depression.

Table AMM-B: Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485 G0409–G0411	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 077x, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	***WITH***	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

Step 2 Determine the IESD. For each member identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the member had more than one encounter during the Intake Period, include only the first encounter.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/encounter for any diagnosis of major depression (Table AMM-A) or prior episodes of depression (Table AMM-C) during the 120 days prior to the IESD.

Table AMM-C: Additional Codes to Identify Depression

Description	ICD-9-CM Diagnosis
Depression	296.26, 296.36, 296.4-296.9, 309.0, 309.28

Step 4 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table AMM-D) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude members who did not fill a prescription for an antidepressant medication during this period.

Step 5 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD.

***Step* 6** Calculate continuous enrollment. Members must be continuously enrolled for 120 days prior to the IESD to 128 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerators

Optimal practitioner contacts for medication management Three or more outpatient, intensive outpatient or partial hospitalization follow-up visits with a practitioner (at least one of which is a prescribing practitioner) within the 84-day Acute Treatment Phase after a new diagnosis of major depression. All three follow-up visits should be for mental health. Two of the three follow-up visits must be face-to-face. Case management services should not be counted toward this measure.

Identify all members in the denominator population who met one of the following criteria.

Three face-to-face visits (Table AMM-E) with a practitioner within 84 days (12 weeks) after the IESD, ***or***

Two face-to-face visits and one telephone visit (Table AMM-E) with a practitioner within 84 (12 weeks) days after the IESD

Do not count the IESD visit in cases where the member had two visits with a secondary diagnosis of major depression. The organization may include the second visit with a secondary diagnosis toward the optimal contacts rate.

Table AMM-E: Codes to Identify Visits

Description	CPT	HCPCS	UB Revenue
Visits identified by the following CPT, HCPCS and UB Revenue codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).			
Face-to-face visits	90804-90815	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0513, 0900-0905, 0907, 0911-0917, 0919

Description	CPT	UB Revenue
Visits identified by the following CPT and UB Revenue codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code (Table MPT-A).		
Face-to-face visits	98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	0510, 0515-0517, 0519-0523, 0526-0529, 077x, 0982, 0983
Telephone visits	99371-99373	

Description	CPT		POS
Visits identified by the following CPT/POS codes may be with a mental health or non-mental health practitioner (i.e., the organization does not need to determine practitioner type).			
Face-to-face visits	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875, 90876	***WITH***	05, 07, 11, 12, 15, 20, 22, 49, 50, 52, 53, 71, 72
Face-to-face visits	90816-90819, 90821-90824, 90826-90829	***WITH***	52, 53
Visits identified by the following CPT/POS codes must be with a mental health practitioner *or* in conjunction with any mental health diagnosis code (Table MPT-A).			
Face-to-face visits	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263	***WITH***	52, 53

The organization must verify that at least one of the three follow-up visits was with a prescribing practitioner (this may be the telephone visit). Members who did not receive a follow-up visit within the 12-week Acute Treatment Phase with a prescribing practitioner are not counted in the numerator for Optimal Practitioner Contacts rate.

Note

- *The intent of the telephone visit is that the exchange occurred between the patient and one of the practitioner types (mental health and non-mental health practitioners) that count for face-to-face visits. Do not count contacts from other types of services (e.g., disease management, case management) toward the Optimal Practitioner Contacts measure.*
- *A member with a mental health benefit whose claim for follow-up visits is denied is included in the denominator of this measure but must also meet all other eligibility requirements for inclusion.*
- *Definition of* mental health practitioner *and* prescribing practitioner (from HEDIS 2011 tech specs Appendix 3).

Prescribing practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Mental health practitioner — A practitioner who provides mental health services and meets any of the following criteria.

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice
- An individual who is licensed as a psychologist in his/her state of practice
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)

Indicator 21: Increasing post-partum depression (PPD) screening in primary care

Description: The percent of a sample of Live birth providers who had a woman diagnosed with Depression/Post-Partum Depression who also used an approved Post-Partum depression screening tool.

Denominator: A sample of 20 high volume live birth providers per BHO who had a woman diagnosed with Depression/Post-Partum Depression.

Numerator: All live birth Providers in the denominator who use an approved Post-Partum depression screening tool.*

*Post-Partum Depression screening tool = Any commonly used depression or postpartum depression screening tool, such as the Edinburgh, PHQ-2, PHQ-9, and the Beck Depression Inventory. Questions regarding depression on a postpartum medical intake form can count as a "depression screening tool," so long as the intake form asks (minimally) the two questions on the PHQ-2.

Data Source(s): Global bill for live birth data and diagnosis of Depression/Post-Partum Depression. Physical health claims for diagnosis of Depression/Post-Partum Depression. Refer to **Table 14 for the criteria HCPF uses collect the data.**

Calculation of Measure: HCPF and BHO

- HCPF to provide quarterly data about live births providers that diagnosed Depression post birth to the BHOs. The data will show providers by BHO area. 20 providers for the measurement year will be the denominator for each BHO.
- Every measurement year, BHO's will call the 20 high volume providers in their counties to see which provider uses an approved Post-Partum Depression tool. After three attempts the provider will be considered non responsive and BHO's may go down the list of providers until they have received information from at least 20 providers. The number of providers that use an approved Post-Partum Depression tool will be the numerator of the measure for the BHO.
- BHO's will use the standardized script provided when calling the providers. **Please refer to Appendix O for the script.**

Benchmark: Overall BHOs

Issues:

1. Caveat as to completeness of data – Medicare Part B does not share their data; as a result any data on Medicare Dual-Eligible individuals should be considered incomplete. This issue may be revisited once changes to this process are made.

TABLE 14

Criteria Used to Collect Post-Partum Measure Data

Identify live births between XX/XX/XX-XX/XX/XX with 60 run out (XX/XX/XX).

Claim type E (Practitioner)

Procedure Codes:
59000','59001','59012','59015','59020','59025','59030','59050','59051','99500','76801','76802','76803','76804','76805','76806','76807','76808','76809','76810','76811','76812','76813','76814','76815','76816','76817','76818','76819','76825','59897','59070','59072','59074','59076','59400','59510','59425','59426','59610','59618','99201','99202','99203','99204','99205','99206','99207','99208','99209','99210','99211','99212','99213','99214','99215'

Procedure Code Modifier 1,2,3,4 ='TH'

Identify client's assigned BHO Provider using Client Monthly Reports "Mental Provider"

Create client list from Live Births data pull
Use external list manager to create client list in COGNOS to pull depression related claims for identified clients

Identify depression related post-birth claims between XX/XX/XX-XX/XX/XX with 60 runout (XX/XX/XX)

Claim type E (Practitioner)
Diagnosis Code 1, 2, 3, or 4 = '296.2','296.20','296.21','296.22','296.23','296.24','296.25',
'296.26','296.3','296.30','296.31','296.32','296.33','296.34','296.35','296.36','311','648.44', '648.43

Identify client's assigned BHO Provider using Client Monthly Reports "Mental Provider"

Use external list manager to create client list in COGNOS to pull depression related claims for identified clients

Identify depression related post-birth claims between XX/XX/XX-XX/XX/XX with 60 run out (XX/XX/XX)

Claim type C (Outpatient) for FQHC

Provider Type 32
Diagnosis Code 1, 2, 3, or 4 = '296.2','296.20','296.21','296.22','296.23','296.24','296.25',
'296.26','296.3','296.30','296.31','296.32','296.33','296.34','296.35','296.36','311','648.44', '648.43
Identify client's assigned BHO Provider using Client Monthly Reports "Mental Provider"

SCRIPT FOR OB/GYN CALLS RE POST-PARTUM DEPRESSION

Introduction

Good morning. This is _____ calling on behalf of (BHO name). (BHO name) is the company that manages Medicaid behavioral health benefits in your area.

As part of (BHO name) depression initiative, we are interested in gathering information on how depression is identified in your post-partum patients.

(*If questioned about the nature of the call, caller may state: This not a sales call. I represent the behavioral health organization in your area for patients with Medicaid.)*

1. I have a few questions and would like to speak with the practice manager or nurse who is familiar with your practice procedures.
   Who would that person be? (Name) _____
2. (*If person is not available*) What would be a good time to reach (Name)?
3. What telephone number should I use to reach (Name), or would it be more efficient to send an email?

List phone number: _____or List email address: _____

Information Gathering

Good morning, Dr./Mr./Ms. _____. This is _____ from **(**BHO name), a company that manages Medicaid behavioral health care in (county where practice located).

We have an initiative to improve detection of depression in medical provider offices and are interested in how your practice identifies depression in post-partum patients. You were selected for this call because within the last few months, your practice submitted one or more claims to Medicaid for patients with a diagnosis of depression. I have just a few questions for you and it will only take five minutes.

Some practices use a screening or evaluation tool to make the diagnosis of post-partum depression, such as the Edinburgh, PHQ-2, PHQ-9, or Beck Depression Inventory (BDI).

Do you use a depression screening tool in your practice? **Yes (go to #1)** **No (go to #2)**

1. **(If YES)** Which one do you use? _____

   a. Do you give this assessment to all new mothers? Yes No

      i. (If YES): When do they get the assessment? _____

      ii. (If NO) How do you select which patients to assess? _____

      _____

2. **(If NO)** We would like to follow-up with you on the possibility of implementing a screening tool. Are you interested in more information about screening for post-partum depression?
   Yes *(go to 2a)* No *(end call)*

   a. ***(If YES):*** To whom can I send the information or would you be the right person to contact?
      _____

Thank you again for taking the time to talk to me. Have a good day.

Indicator 22: Change in recovery and resilience

Description: The mean change in the resiliency subscale, for clients age 6-17 years with a severe emotional disorder (SED), and in the recovery subscale, for clients age 18+ years with a severe mental illness, within an episode of care or at the last update of an episode of care. There is one episode of care per client. The episode of care begins with the admit CCAR or the first update CCAR after 7/1/07.

See **Table 15 for CCAR outcome items for the subscales by age group**. There will be three indicators for this performance measure: Improvement in resiliency for adolescents; Improvement in resiliency for children; and Improvement in recovery for adults.

Denominator: Total number of unduplicated members, age 12–17 years or 6-11 years with a SED (**see Table 15** below for calculation) or age 18+ years with a SMI (see **Table 15 for calculation**), with a discharge CCAR, or if no discharge CCAR, the most recent update CCAR in the study period and a previous admit CCAR or first update CCAR beginning 7/1/2007. The discharge CCAR must be a type 1, 2, 3, or 7 and if the discharge CCAR is 1 or 7, the client length of stay, from admit, must be greater than 180 days. The pre CCAR resiliency or recovery subscale mean must be $\geq$ 2. The client must be a member of the same BHO on the date of both CCARs.

Numerator: Total change score, from admit or update to discharge or update CCAR, for the appropriate resiliency or recovery subscale for clients in the denominator

Data Source(s): CCARs beginning with 7/1/07.

Calculation of Measure: HCPF.

Benchmark:

Issues:
Need to coordinate with DBH regarding the factor changes and criteria for calculating this indicator

TABLE 15

Colorado Client Assessment Record Subscale Items for Change in Recovery and Resiliency

CCAR Resiliency Subscale Items Adolescent	CCAR Resiliency Subscale Items children	CCAR Recovery Subscale Items Adults
Hope	Hope	Hope
Activity Involvement	Activity Involvement	Activity Involvement
Social Support	Social Support	Social Support
Empowerment	Empowerment	Empowerment
Interpersonal		Interpersonal
Role Performance	Role Performance	
Family		

Definition and Method for Calculating Severe Emotional Disorder (SED) for Youth:

Step 1. Diagnosis
Exclusions: Children and Adolescents with one of the following **AXIS I Primary Diagnoses DO NOT** meet the **Seriously Emotionally Disturbed (SED)** Severity category.

Description	**Primary Diagnosis Code** (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementia & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X

Description	**Primary Diagnosis Code** (217)
Autistic Behaviors	299.00, 299.10, 299.80
Developmental Disabilities	315.00, .1, .2, .31, .32, .39, .4, .9
Stuttering	307.0
Other	799.9, V71.09

Step 2. Problem Severity Scales
Children and Adolescents rated at the indicated problem severity level in at least one of the following areas on the CCAR form are **Seriously Emotionally Disturbed (SED).**

P-SEV Scale	**Level Value**
Legal (385)	"7-9"
Psychosis (389)	"7-9"
Attention (391)	"7-9"

Manic Issues (392)	"7-9"
Anxiety Issues (393)	"7-9"
Depressive Issues (394)	"7-9"
Family (397)	"7-9"
Socialization (399)	"7-9"
Role Performance (400)	"7-9"

Step 3. Problem Type
Children and Adolescents judged to have at least **ONE** problem from the following list on the CCAR form are **Seriously Emotionally Disturbed (SED).**

Problem	**Problem Value**
Victim: Sexual Abuse (355)	"1"
Victim: Physical Abuse (357)	"1"
Sexual Misconduct (314)	"1"
Danger to Self (315)	"1"
Injures Others (316)	"1"
Injury by Abuse/Assault (317)	"1"
Reckless Self-Endangerment (318)	"1"
Suicide Ideation (319)	"1"
Suicide Plan (320)	"1"
Suicide Attempt (321)	"1"

Step 4. Residence & Living Arrangement
Children and Adolescents in a place of residence meeting one of the following criteria on the CCAR form are **Seriously Emotionally Disturbed (SED).**

Residence & Living Arrangement	**Value**
(Place of Residence (270)	All codes except 13, 14, and 15) **OR**
(Current Living Arrangement: Foster Parent (277)	"1") **OR**
(Current Living Arrangement: Unrelated Person(s) (282) Mother (273) Father (274) Spouse (279) Partner/Significant Other (280)	 "1" **AND** "0" **AND** "0" **AND** "0" **AND** "0")

Children and Adolescents who do not meet any of the above criteria are **NOT SED.**

TABLE 16

Severe Mental Illness includes Adults with SPMI and SMI; all steps 1-3 must be completed in order to calculate the full list of Adults with SMI.

Step 1. Diagnosis

Exclusions -Adults and Older Adults with the following **AXIS I Primary Diagnoses** on the CCAR form automatically **DO NOT MEET ANY OF THE SEVERITY LEVEL CATEGORIES.**

Description	**Primary Diagnosis Code** (217)
Mental Retardation	317, 318.X, 319
Alcohol	291.X, 303.XX, 305.00
Substance	292.XX, 304.XX, 305.10-90
Dementias & other diagnoses due to medical conditions	290.XX, 293.XX, 294.X, 310.X
Other	799.9, V71.09

Step 2. SPMI – Serious and Persistent Mental Illness

For an Adult or Older Adult to meet the criteria for **SPMI**, s/he must first pass the Exclusion criteria in Step 1 and then meet the criteria in the History and/or Self Care categories below: Any **THREE** of the following History items on the CCAR form must be met:

History Criteria	**Value**
SSI (265)	"1"
SSDI (266)	"1"
Presenting Problem has Existed (283)	"1"
Inpatient Care (360)	"1"
Other 24-Hour Care (361)	"1"
Partial Care (362)	"1"

Or any four of the following Self Care Items must be met:

Self Care Criteria	**Value**
Place of Residence (270)	All codes except "12" and "15"
Self Care Problems (294)	"1"
Food Attainment (295)	"1"
Housing Access (296)	"1"
Self-Care/Basic Needs (384)	"7-9"

Step 3. SMI not SPMI

For those cases remaining (not excluded by diagnosis and not SPMI): Severity level is determined by the presence of a **Serious Mental Illness** as defined by these diagnosis codes:

Description	**Primary Diagnosis Code** (217)
Schizophrenia & other Psychosis	295.1X, .2X, .3X, .6X, .9X
Paranoid	297.1, 297.3
Other Psychosis	295.4X, .7X, 298.8, .9
Major Affective	296.X, 296.XX, 300.4, 311
Personality Disorder	301.0, .20, .22
Dissociative Identify Disorder	300.14
Post-Traumatic Stress	309.81 **plus** the score for the Overall Symptom Severity must be a 4 or higher.

Any adult not meeting the SPMI or SMI not SPMI criteria is not SMI.

NOTE: A client meeting both SPMI and SMI not SPMI is recorded in the Management Information System as SPMI.

Serious Mental Illness (SMI) – The national definition for SMI is much broader than the one used in Colorado. To update the Colorado severity level categories, the Division of Mental Health will combine SPMI and SMI not SPMI into a single SMI category